

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-04-6344.M5

MDR Tracking Number: M5-04-0474-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-15-03.

The IRO reviewed office visits/outpatient, joint mobilization, myofascial release, manual traction therapy, therapeutic exercises, functional capacity evaluation, range of motion measurements, work hardening and conductive past or gel rendered from 02-20-03 through 05-16-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
2-20-03 through 3-12-03 (6 DOS)	99213	\$288.00 (1 unit @ \$48.00 X 6 DOS)	\$0.00	V	\$48.00	IRO Decision	Reimbursement recommended in the amount of \$48.00 X 6 DOS = \$288.00
2-20-03 through 3-11-03 (5 DOS)	97265	\$215.00 (1 unit @ \$43.00 X 5 DOS)	\$0.00	V	\$43.00	IRO Decision	Reimbursement recommended in the amount of \$43.00 X 5 DOS = \$215.00
2-20-03 through 3-11-03 (5 DOS)	97250	\$215.00 (1 unit @ \$43.00 X 5 DOS)	\$0.00	V	\$43.00	IRO Decision	Reimbursement recommended in the amount of \$43.00 X 5 DOS = \$215.00
2-20-03	97122	\$175.00	\$0.00	V	\$35.00	IRO	Reimbursement

through 3-11-03 (5DOS)		(1 unit @ \$35.00 X 5 DOS)				Decision	recommended in the amount of \$35.00 X 5 DOS = \$175.00
3-12-03	97750- FC	\$500.00 (1 unit)	\$0.00	V	\$500.00	IRO Decision	Reimbursement recommended in the amount of \$500.00

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
2-20-03 through 3-11-03 (5 DOS)	97110	\$875.00 (5 units @ \$175.00 X 5 DOS)	\$0.00	V	\$35.00	IRO Decision	Reimbursement recommended in the amount of \$175.00 X 5 DOS = \$875.00
3-10-03	95851	\$108.00 (1 unit @ \$36.00 X 3 units)	\$0.00	V	\$36.00	IRO Decision	Reimbursement recommended in the amount of \$36.00 X 3 units = \$108.00
3-13-03 through 5-16-03 (5 DOS)	99213	\$240.00 (1 unit @ \$48.00 X 5 DOS)	\$0.00	V	\$48.00	IRO Decision	No reimbursement recommended.
3-13-03 through 5-6-03 (33 DOS)	97545- WH	\$4,224.00 (1 unit @ \$128.00 X 33 DOS)	\$0.00	V	\$64.00	IRO Decision	No reimbursement recommended.
3-13-03 through 5-6-03 (33 DOS)	97546- WH	\$12,032.00 (6 units @ \$384.00 X 30 DOS, 1 unit @ \$128.00 X 2 DOS and 4 units @ \$256.00 X 1 DOS)	\$0.00	V	\$64.00	IRO Decision	No reimbursement recommended.
3-27-03	A4558	\$18.00 (1 unit)	\$0.00	V	DOP	IRO Decision	No reimbursement recommended.
4-21-03	97750- FC	\$200.00 (1 unit)	\$0.00	V	\$200.00	IRO Decision	No reimbursement recommended.

TOTAL	\$18,807.00		The requestor is entitled to reimbursement of \$ 2,376.00
-------	-------------	--	---

The IRO concluded that office visit/outpatient, joint mobilization, myofascial release, manual traction therapy, functional capacity evaluation, therapeutic exercises and range of motion measurements from dates of service 03-13-03 through 05-16-03 and work hardening program and conductive past or gel **were not** medically necessary. The IRO concluded that office visit/outpatient, joint mobilization, myofascial release, manual traction therapy, functional capacity evaluation, therapeutic exercises and range of motion measurements from dates of service 02-20-03 through 03-12-03 **were** medically necessary.

On this basis, the total amount recommended for reimbursement (\$2,376.00) does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-19-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$	Reference	Rationale
4-3-03	99213	\$48.00 (1 unit)	\$0.00	D	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor nor respondent submitted original explanation of benefits. Reviewer cannot determine original reason for denial. No reimbursement recommended.
4-10-03 through 6-9-03 (6 DOS)	99213	\$288.00 (1 unit @ \$48.00 X 6 DOS)	\$0.00	NO EOB	\$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement

							recommended.
3-12-03	97265	\$43.00 (1 unit)	\$0.00	NO EOB	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
3-12-03	97250	\$43.00 (1 unit)	\$0.00	NO EOB	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
3-12-03	97122	\$35.00 (1 unit)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
3-12-03	97110	\$175.00 (5 units)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
4-17-03	E0745	\$264.00 (1 unit)	\$0.00	NO EOB	DOP	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
4-18-03 through 5-8-03 (5 DOS)	97545-WH	\$640.00 (2 units @ \$128.00 X 5 DOS)	\$0.00	NO EOB	\$64.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Maximum Allowable Reimbursement)	Reference	Rationale
4-18-03 through 5-8-03 (5 DOS)	97546-WH	\$1,792.00 (6 units @ \$384.00 X 4 DOS, 4 units @ \$256.00 X 1 DOS)	\$0.00	NO EOB	\$64.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
5-8-03	99080-73	\$15.00	\$0.00	NO EOB	\$15.00	Rule 133.106(f)	Requestor did not submit relevant information to support

							delivery of service. No reimbursement recommended.
5-5-03	97545-WH	\$128.00 (1 unit)	\$0.00	F	\$64.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		\$3,518.00	\$0.00				The requestor is not entitled to any reimbursement.

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 4th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 02-20-03 through 06-09-03 in this dispute.

This Order is hereby issued this 4th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

April 30, 2004

REVISED REPORT
Corrected dates of service and decision.

MDR #: M5-04-0474-01
IRO Certificate No.: IRO 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine.

Clinical History:

This male claimant was injured at work on _____. He fell on the right side of his body and injured his right wrist, right ankle, and low back. He was taken to the emergency room where X-rays revealed no fractures. He went to the company doctor. He later changed treating doctors and conservative physical therapy was begun. An EMG of his lower extremity was negative, as was an MRI of the lumbar spine. An FCE on 03/12/03 determined that the patient had deficiencies to perform his job requirements.

The counselor's notes during the work hardening program indicate that the patient has no psych issues and was very cooperative. There is an absence of pathological findings noted by the MRI. The FCE showed the patient's participation to be valid.

Disputed Services:

Office visit/outpatient, joint mobilization, myofascial release, manual traction therapy, therapeutic exercises, functional capacity evaluation, range of motion measurements, work hardening, and conductive past or gel during the period of 02/20/03 through 05/16/03.

Decision:

The reviewer partially agrees with the determination of the insurance carrier and is of the opinion that the office visit/outpatient, joint mobilization, myofascial release, manual traction therapy, functional capacity evaluation (03/12/03), therapeutic exercises, and range of motion measurements during the period of 02/20/03 through 03/12/03 were reasonable and medically necessary. These same treatments were not medically necessary during the period of 03/13/03 through 05/16/03. Also, the work hardening program and the conductive paste or gels were not medically necessary.

Rationale:

Conservative care that consists of active rehabilitation and therapy to return the injured employee to pre-accident status is a recommended treatment protocol as cited by the *Texas Spine Treatment Guidelines* and *Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters*. Average treatment lengths range from 6 to 8

weeks. Therefore, the services in dispute as stated above provided between 02/20/03 and 03/12/03 were reasonable and medically necessary.

Although the FCE showed evidence of the patient's deficiencies to perform his job requirements, this does not automatically qualify him for a work hardening program. Work hardening involves a multi-disciplinary approach and is reserved, typically, for outliers of the normal patient population, i.e., poor responders to conventional treatment intervention with significant psychosocial issues and extensive absence from work (*CARF Manual for Accrediting Work Hardening Programs*).

Additionally, no significant psychosocial or other barriers to recovery were identified, with the only indication of any psychosocial involvement coming from the battery of psychological screening measures. There is also an absence of pathological findings noted by the MRI. The counselor's notes, showed the patient to have no psych issues and very cooperative.

According to the available documentation, the patient's continued problems were limited to strength and mobility loss. Pain levels are highly subjective and cannot be used as a qualifier. No other complicating factors or barriers to recovery seemed to be present to suggest that anything more than a focused strengthening/rehabilitation program was necessary.

I am the Secretary and General Counsel of ____ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,